Provider category	Basis of reimbursement	Upper limit
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)*"g"* and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater. *[For services rendered from February 1, 2002, through June 30, 2002: The reasonable cost of covered services provided to medical assistance recipients less 13.2% or the upper limits for other hospitals, whichever is greater.]
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/01 less 3%. *[For services rendered from February 1, 2002, through June 30, 2002: Reimbursement rate in effect 1/31/02 less 13.2%.]
Hospitals (Outpatient)	Prospective reimbursement for providers listed at 441—paragraphs 78.31(1)*"a"* to *"f."* See 79.1(16)	Ambulatory patient group rate (plus an evaluation rate) and assessment payment rate in effect on 6/30/01 less 3%. *[For services rendered from February 1, 2002, through June 30, 2002: Ambulatory patient group rate (plus an evaluation rate) and assessment payment rate in effect on 1/31/02 less 13.2%.]
	Fee schedule for providers listed at 441—paragraphs 78.31(1)*"g"* to *"n."* See 79.1(16)	Rates in effect on 6/30/01 less 3%. *[For services rendered from February 1, 2002, through June 30, 2002: Rates in effect 1/31/02 less 13.2%.]
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native recipients. 2. Fee schedule for service provided for all other Medicaid recipients.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate. 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule
Intermediate care facilities for the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from 12/31/00 cost reports

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Provider category	Basis of reimbursement	Upper limit
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/01 less 3%. *[For services rendered from February 1, 2002, through June 30, 2002: Fee schedule in effect 1/31/02 less 13.2%.]
Local education agency services providers	Fee schedule	Fee schedule
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/01 less 3%. *[For services rendered from February 1, 2002, through June 30, 2002: Fee schedule in effect 1/31/02 less 13.2%.]
Nurse-midwives	Fee schedule	Fee schedule in effect 6/30/01 less 3%. *[For services rendered from February 1, 2002, through June 30, 2002: Fee schedule in effect 1/31/02 less 13.2%.]

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Provider category	Basis of reimbursement	Upper limit
Nursing facilities:		
1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6 (16)"*d*"(1)"1" and (2)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 100%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)"*d*"(1)"2" and (2)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 65%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)"*f.*" The direct care rate component limit under 441—81.6(16)"*f*"(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)"*f*" (1) and (2) is 110% of the patient-day-weighted median. *[For services rendered from February 1, 2002, through June 30, 2002, the rate otherwise provided shall be reduced by 13.2%.]

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Provider category	Basis of reimbursement	Upper limit
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(3)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 100%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(3)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 65%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14), and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"*(3) is 110% of the patient-day-weighted median. *[For services rendered from February 1, 2002, through June 30, 2002, the rate otherwise provided shall be reduced by 13.2%.]
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/01 less 3%. *[For services rendered from February 1, 2002, through June 30, 2002: Fee schedule in effect 1/31/02 less 13.2%.]
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/01 less 3%. *[For services rendered from February 1, 2002, through June 30, 2002: Fee schedule in effect 1/31/02 less 13.2%.]
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/01 less 3%. *[For services rendered from February 1, 2002, through June 30, 2002: Fee schedule in effect 1/31/02 less 13.2%.]

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Provider category	Basis of reimbursement	Upper limit
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18)
Physical therapists	Fee schedule	Fee schedule in effect 6/30/01 less 3%. *[For services rendered from February 1, 2002, through June 30, 2002: Fee schedule in effect 1/31/02 less 13.2%.]
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)	Fee schedule in effect 6/30/01 less 3%. *[For services rendered from February 1, 2002, through June 30, 2002: Fee schedule in effect 1/31/02 less 13.2%.]
Podiatrists	Fee schedule	Fee schedule in effect 6/30/01 less 3%. *[For services rendered from February 1, 2002, through June 30, 2002: Fee schedule in effect 1/31/02 less 13.2%.]
Prescribed drugs	See 79.1(8)	$5.17 dispensing fee. *[For services rendered from February 1, 2002, through June 30, 2002: $4.48 dispensing fee.] (See 79.1(8)*"a"* and *"e"*)
Psychiatric medical institutions for children		
(Inpatient)	Prospective reimbursement	Reimbursement rate for provider based on per diem rates for actual costs on 6/30/00, not to exceed a maximum of $147.20 per day
(Outpatient day treatment)	Fee schedule	Fee schedule in effect 6/30/01 less 3%
Psychologists	Fee schedule	Fee schedule in effect 6/30/01 less 3%. *[For services rendered from February 1, 2002, through June 30, 2002: Fee schedule in effect 1/31/02 less 13.2%.]
Rehabilitation agencies	Retrospective cost-related	Fee schedule in effect 6/30/01 less 3%. *[For services rendered from February 1, 2002, through June 30, 2002: Fee schedule in effect 1/31/02 less 13.2%.]

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Provider category	Basis of reimbursement	Upper limit
Rehabilitation services for adults with a chronic mental illness providers, including:		
1. Rehabilitation support services providers, including:		
Community living skills training services providers	Retrospective cost-related. See 79.1(19)	Retrospective rate
Employment-related services providers	Retrospective cost-related. See 79.1(19)	Retrospective rate
2. Day program services providers, including:		
Skills training providers	Retrospective cost-related. See 79.1(19)	Retrospective rate
Skills development providers	Retrospective cost-related. See 79.1(19)	Retrospective rate
Rehabilitative treatment services	Reasonable and necessary costs per unit of service based on data included on the Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049. See 441—185.101(234) to 441—185.112(234). A provider who is an individual may choose between the fee schedule in effect November 1, 1993 (See 441—subrule 185.103(7)) and reasonable and necessary costs.	Rate in effect on 6/30/01
Rural health clinics (RHC)	Retrospective cost-related See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.

Provider category	Basis of reimbursement	Upper limit
Screening centers	Fee schedule	Reimbursement rate for center in effect 6/30/01 less 3%. *[For services rendered from February 1, 2002, through June 30, 2002: Reimbursement rate in effect 1/31/02 less 13.2%.]
State-operated institutions	Retrospective cost-related	

79.1(3) *Ambulatory surgical centers.* Payment is made for facility services on a fee schedule determined by Medicare. These fees are grouped into eight categories corresponding to the difficulty or complexity of the surgical procedure involved. Procedures not classified by Medicare shall be included in the category with comparable procedures.

Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)*"c"*). This payment is made directly to the physician or dentist.

79.1(4) *Durable medical equipment, prosthetic devices, medical supply dealers.* Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality.

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

"Adolescent" shall mean a Medicaid patient 17 years or younger.

"Adult" shall mean a Medicaid patient 18 years or older.

"Average daily rate" shall mean the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

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